

INFORMATIONAL LETTER NO. 2062-MC-FFS

DATE: November 18, 2019

TO: All Iowa Medicaid Providers (Excluding Indian Health Service)

Applies To: Managed Care (MC), Fee-for-Service (FFS)

FROM: Iowa Department of Human Services (DHS), Iowa Medicaid

Enterprise (IME)

RE: Emergency Room (ER) Visits and Emergency Diagnosis Codes

EFFECTIVE: July 1, 2018

This Letter clarifies <u>Informational Letter 1901-MC-FFS1</u>¹ that reminded providers about Medicaid's payment policy regarding services performed in the ER. The policy applies to payments made under FFS as well as MC. The intent of this letter is to clarify processes for providers in cases where the discharge diagnosis listed on a claim does *not* include code(s) from <u>the list</u>² automatically recognized as emergent in nature. In these cases, the claim can still be paid in full if the encounter appeared emergent under the Prudent Layperson Standard, when considering the fuller context of the underlying medical record. The process descriptions below indicate how providers can request this review as part of the original claim consideration.

FFS: The Provider Inquiry form and submission process is described in the General Program Policies section of the <u>Provider Manual</u>³ on page 44. Such an inquiry should be sent along with related documentation supporting why the claim should be considered emergent in nature. When the claim is received, it is reviewed by Medical Services personnel for a potential payment at the full, emergent rate. *This inquiry process can be utilized as an original step of the claim submission; providers do not need to receive a payment cutback first before sending a claim inquiry in for this type of consideration.*

¹ https://dhs.iowa.gov/sites/default/files/1901-MC-

FFS EmergencyRoomVisitsandEmergencyDiagnosisCodes.pdf?110520191630

² https://dhs.iowa.gov/sites/default/files/ICD-10 Emergency Dx 3.pdf?111520192253

³ https://dhs.iowa.gov/policy-manuals/medicaid-provider

Amerigroup lowa, Inc. (Amerigroup): The process for review of ER claims that did not have an emergent diagnosis code can follow a Prospective Review Process for emergency department (ED) claims that do not have a defined emergent ICD-10 diagnosis code billed on the claim form. This process allows providers and facilities to have their claims and medical records reviewed for medical emergency determination prior to the claim being processed. The provider or facility may attach the complete ED medical record to the claim upon initial claim submission. The claim and records will be pended for clinical review to determine if the services provided are a valid emergency medical condition. A Retrospective Review Process is available for claims that have been filed and processed as not meeting emergency department criteria as well. These processes are outlined in the Amerigroup manual⁴.

Iowa Total Care (ITC): The process for review of ER claims with non-emergent codes is by request of the facility/provider. This may be requested when claims submitted do not have an emergent ICD-10 diagnosis code as the primary diagnosis prior to claim payment. The facility/provider may request a review of claims submitted for Emergency Room visits either retrospectively or prospectively. For prospective review, this would fall under the Medically Necessary section of the ITC Provider Manual. The retrospective review process is through a Provider Claim Dispute, which is also documented in the ITC Provider Manual.

The IME appreciates your continued partnership as we work to improve the claim processing service quality and accuracy. If you have questions, please contact the IME Provider Services Unit at 1-800-338-7909 or email at imeproviderservices@dhs.state.ia.us.

https://providers.amerigroup.com/ProviderDocuments/IAIA ProviderManual.pdf

⁵ https://www.iowatotalcare.com/content/dam/centene/iowa-total-care/PDF/Iowa%20Provider%20Manual%2007.25.19.pdf